Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Professions Licensure

Board of Registration in Pharmacy
239 Causeway Street, 5th Floor, Boston, MA 02114
617-727-9953 (office) 617-727-2366 (fax)
www.mass.gov/reg/boards/ph

MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

RONALD PRESTON
SECRETARY

CHRISTINE C. FERGUSON
COMMISSIONER

APPLICATION FOR A CHANGE IN MANAGER OF A PHARMACY OR PHARMACY DEPARTMENT

Whenever a pharmacy or pharmacy department is to be managed by a registered pharmacist other than the pharmacist who completed the initial application for registration to manage and operate the pharmacy or pharmacy department, an application for a change in pharmacist Manager of Record must be promptly submitted to the Board of Registration in Pharmacy. All applications must contain the following:

1. An Application for a Manager of Record change (enclosed and or available on the website), must be completed and signed by the new registered pharmacist designated to manage and operate the pharmacy or pharmacy department.

2. A complete inventory of controlled substances in Schedule II, III, IV, and V, must be signed by both the outgoing and incoming pharmacist Managers of Record. In the event the outgoing pharmacist Manager of Record is unavailable due to death, serious illness, termination for inappropriate handling of controlled substances, or other emergency mitigating circumstances beyond control, a designated staff pharmacist shall sign the inventory and a company official shall submit to the Board a written report setting out the circumstances which prevented the pharmacist Manager of Record from signing the inventory.

3. The pharmacy permit and the certificate of fitness, if applicable, issued under the outgoing Manager of Record's name (Do not return controlled substance permit).

4. A Store Hours form (enclosed and or available on the website), completed to reflect the hours during which the pharmacy or pharmacy department is to remain open.

5. An Application, if applicable, for a new Certificate of Fitness (enclosed and or available on the website).

6. A check or money order made payable in the proper amount to the Commonwealth of Massachusetts.

Please be advised that no application for registration to manage and operate a pharmacy or pharmacy department shall be acted upon by the Board less than 15 days after receipt by the Board of the fully and properly completed application. For complete information regarding such regulations, please refer to 247 CMR 6.03(1).

If additional information is necessary, please contact the Board office at (617) 727-9953.

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APPLICATION FOR A CHANGE OF MANAGER

BOARD USE ONLY
Board_____
License #_____
Type_____
Cash #_____
Cash Date_____

I hereby apply for a permit to operate a store for the transaction of retail drug business in accordance with the provisions of Chapter 112, General Laws.

$351.00 licensure / application fee. Make check or money order for **$351.00** payable to the Commonwealth of Massachusetts. **This fee is non-refundable.**

1. Legal Name of Business._____

BOARD USE ONLY
Status Code_____ **Issue Date**_____ **Lic. Exp. Date**_____

2. Full Business Address (Street Address, City, State and Zip)._____
_____

3. Area Code and Telephone Number._____

4. All trade or business names ("D.B.A." names) used by same Corporation or by Licensee._____
_____
_____

5. Type of ownership or operation (i.e. sole proprietorship, partnership, corporation)._____
_____
If corporation, please submit articles of corporation.

6. Name(s) and Social Security Number(s) of the owner(s) and/or operator(s) of the license.
Please indicate type of ownership-Partnerships: the name of each partner and name and address of

partnership; Corporations: the name and title of each corporate officer and director, the corporate names, name and address of parent company, if any, and the State of incorporation; Sole Proprietorships: the name of the sole proprietor and the name and address of the business entity.

7. Name of registered pharmacist previously charged with the management of the pharmacy.

8. Registration number of the previous manager.

9. Name of registered pharmacist who is applying to manage the pharmacy.

10. Registration number of the pharmacy manager applicant.

11. Name(s) and registration number(s) of staff pharmacist(s) employed at pharmacy.

12. Have any of the applicant(s) and/or managers-in-charge had: 1) any convictions related to the distribution of drugs (including samples); 2) any felony convictions; 3) any suspension(s) or revocation(s) or other sanction(s) by federal, state or local governmental agency of any license or registration currently or previously held by the applicant or license for the manufacture, distribution, or dispensing of any drugs, including controlled substances? Have any applications for licensure been denied by any federal or state agency including any state boards of pharmacy? List and explain. Attach additional sheets, if necessary.

13. The applicant/licensee must notify the Board in writing of any changes in ownership or management within thirty (30) days of such change(s).

Affidavit (must be completed and notarized).

Pursuant to M.G.L. c. 62C, s. 49A, I certify under the penalties of perjury that I, to the best of my knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

The applicant certifies that each person employed in any prescription drug distribution activity has the education, training, and experience, or any combination thereof, sufficient for that person to perform the assigned functions in such a manner as to provide assurance that the drug product quality, safety, and security will at all times be maintained as required by law.

I hereby state that I am the person authorized to sign this application for all licensure; that all statements are
true and correct in all respects and are made under the penalties of perjury.

_____

Signature of pharmacist who is to manage the pharmacy or pharmacy department

_____

Date

_____

Social Security Number of managing pharmacist

Sworn and subscribed before me this_____day of _____

My commission expires_____ . _____
Notary Public

To be completed by the Board: Check $_____ Date_____ Number_____